Eye Care Center of Lake County, Ltd

Patient Name: _____

Patient's date of birth:_____

COMMUNICATION/OFFICE PROTOCOLS/FINANCIAL POLICY EFFECTIVE 1-1-2017

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication.

I have received a copy of the Nondiscrimination and language assistance policy.

Preferred language: [ ] English [ ] Spanish [ ] Other :_____ **Do you require language assistance:** [ ] NO [ ] YES

Electronic Communication is available and we recommend you enroll (Patient Portal/DemandForce). I have received a copy.

Medical records release: a written request is required prior to releasing Protected Health Information (PHI)-forms are available. We will charge the standard fee that is determined by the State of Illinois for medical record copy/release.

HIPAA : I have received a copy of the HIPAA policy.

Treatment of a Minor: For first time visit, a parent or legal guardian must accompany a minor to our office. Follow-up visits: a written letter from a parent(s) and/or legal guardian must be presented if a minor (under 18) is to be seen without the parent or legal guardian present. The person accompanying the minor must present a photo id. The patient is responsible for presenting any insurance cards, copayments, deductibles for the services rendered. **Ultimately the person that accompanies a minor is responsible for payment**.

Our practice participates with a variety of medical insurance plans and Vision Service Plan (VSP).

Please contact our business office if you have any billing questions or concerns. Specific questions regarding your insurance benefits or coverage will be redirected to your insurance member services (the number on the back of your insurance card).

1) Bring your insurance(s) cards to **every visit and government issued ID.** We will submit to the insurance carrier(s) you present at the time of service.
2) If you have insurance that we are not contracted with, **you are responsible for payment in full at the time services are rendered.**
3) If you are unable to pay , it is your responsibility to inform us prior to the visit.
4) If your insurance plan requires a referral **we must have the referral available** at the time of visit or your visit may be rescheduled or you may be responsible for payment.
5) Any copayments, deductibles or coinsurance amounts must be paid at the time of service. We accept cash, credit cards or check. Your check may be processed as an ACH (automatic clearinghouse) transaction.

Vision Service Plans and Optical Services: We will bill optical materials (glasses and contact lenses**) to Vision Service Plan (VSP)** based on your eligibility. If you do not have VSP then you will need to pay for the materials in full at the time of service and submit the bill to your insurance for any reimbursement. This is an estimate and not a guarantee of payment.

Glasses- see our optical policy for frame warranties, remakes, payment, restocking fee, shipping fee. Refraction fee must be paid in full prior to the release of glasses prescription. A copy of your glasses prescription will be provided for your personal information only.

Contact Lens Examination and Fitting Services: are separate from the "Routine Eye Exam" or "Well Vision Exam" and will be billed in addition to your "Routine Eye Exam" should you choose to or need to wear contact lenses. The services include your contact lens wearing history, evaluation/fitting and treatment plan. Our standard fee is $100.00 for regular contacts, $150.00 for Keratoconus exam. You may have coverage for this service if you have VSP; your copayment or coinsurance responsibility is due at time of service. All contact lens exam fees must be paid in full prior to the release of the contact lens prescription. A copy will be provided to you for informational purposes only. All contact lens verifications should be faxed to 847-244-1657.

Return Check Fee: Any payment made by check that does not clear our bank account will result in a $30.00 return check fee and will will be added to your account.

Collection: All open/collection accounts are to be paid before any additional services are rendered.

By signing below I acknowledge receiving and understanding all the above. All questions have been answered to my satisfaction.

Patient or Parent/Guardian (if minor) signature: Date

Printed name of person signing this form if not the patient: